Mistaken HSA Distribution

This form is used when a State Farm Bank® Health Savings Account (HSA) account holder has taken a distribution as a result of a mistake due to reasonable cause, and the account holder elects to repay the mistaken distribution to the HSA. If you have any questions, please call us at 877-734-2265. If you are deaf, hard of hearing, or do not use your voice to communicate, you may contact us via 711 or other relay services.

1 Account information

First name ______ Middle initial ______ Last name ______

Mailing address ______ HSA account number ______

City ______ State ______ ZIP Code ______

Day telephone (including area code) ______ Evening telephone (including area code) ______ Social Security Number ______ Date of birth (MM/DD/YYYY) ______

2 Details of the mistaken distribution

Date of mistaken distribution: ______ Amount of mistaken distribution: ______

Date of mistaken distribution: ______ Amount of mistaken distribution: ______

3 Signature

By signing below you certify:

- There is clear and convincing evidence that the mistaken distribution described above was distributions from the State Farm Bank HSA because of a mistake of fact due to a reasonable cause.
- Confirm that the requested transaction will result in the repayment of the mistaken distribution to the HSA no later than April 15th following the first year that you knew (or should have known) the distribution was taken by mistake.

Signature of account holder ______ Date (MM/DD/YYYY) ______

SIGNATURE